



# **Application**



If you think you might have a physical or mental condition that considerably limits a major life activity, like moving, seeing, hearing, or thinking, let us know. The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. Tell your worker if you think there is something you need.

# If you do not speak English, we can provide free translation for our services. Please tell us if you need an interpreter for any language.

Si usted no habla inglés, podemos proveer traducción gratis para nuestros servicios. Favor de dejarnos saber si necesita un intérprete. (Spanish)

Ako ne govorite engleski, mi vam mozemo za nase usluge obezbjediti besplatnu pomoc prevodioca. Molimo vas da nas obavijestite ako vam je potrebna ova pomoc. (Serbo-Croatian)

Si vous ne parlez pas anglais, nous pouvons vous fournir un traducteur gratuitement pour nos services. Veuillez nous signaler si vous avez besoin d'un interprète. (French)

Nều bạn không biết nói Tiếng Anh, chúng tôi có thể cung cấp sự thông dịch min phí cho nhưng dịch vụ của chúng tôi. Xin vui lòng nói cho chúng tôi biết nều bạn cấn thông dịch viên. (Vietnamese)

#### **Information for Applicants**

**Social Security Numbers.** Everyone applying for benefits must provide a social security number. If you don't have one, ESD will help you apply for one. People not applying for benefits do not have to give a social security number; however, they will have to provide all other information such as income and resources.

**Important Information for Immigrants.** Only U.S. citizens and certain legal aliens can get benefits. If your household includes people who are not eligible because of immigration status, you can still apply for and get benefits for other eligible members. ESD will verify with the Immigration and Naturalization Service the immigration status of noncitizens who apply for benefits. People not applying for benefits do not have to give immigration information.

If you get assistance from us, it may affect your sponsor or your immigration status. Before you apply, you may want to talk with Vermont Legal Aid at 1-800-889-2047 or an agency that helps immigrants with legal questions.

Americans with Disabilities Act. If you think you might have a physical or mental condition that considerably limits a major life activity, like moving, seeing, hearing, or thinking, let us know. The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. Tell your worker if you think there is something that you need.

**Rights and Responsibilities.** When you sign this form, it means you have read and understand your rights and responsibilities on the back of this form. You will get a copy of these to keep. You may ask for a copy in larger print if you would like. If you do not understand your Rights and Responsibilities, ask your worker to explain them to you.

**Confidentiality.** ESD will not share any information from this application except for purposes directly connected with program administration unless you clearly allow release of this information or a court orders it. ESD takes strict precautions to safeguard social security numbers and other confidential information transmitted via the internet or fax machine.

## **The Application Process**

**Answer each question as completely as you can**. Sign the application and give it to the receptionist or mail it to your local office. Please print. If you have questions or need help with this form, your local office can help you. See the back of this form for the addresses and telephone numbers. If you need more room for your answers, please attach another piece of paper.

If you only want food stamps, you just need to answer the questions with the apple ( ) symbol.

If you are applying for food stamps or Reach Up, an interview will be scheduled for you. In certain situations, your food stamp interview can be by phone. At your appointment, your worker will go over this form with you. It is your responsibility to give your worker all the information needed. If you are not able to get this information, ask your worker for help.



# **Application**

This page is your application. You may tear it off and give it to your local office now without the rest of the form. It must have your name, address, and signature. You may mail the rest of the form or bring it to your interview. Please complete the entire form when possible. This information helps us determine if you qualify for emergency benefits. We must have the completed form and all required verification to see if you are eligible.

Applicant	Social security no	Birth date	
Home address			
Mailing address if different	т	ownZip	
Phone number where you can be reach	ned ( <u>)</u> T	own where you live	
Directions to your home			
Do you have an authorized represent	tative or legal guardian?   Yes	☐ No	
If yes, check one: Authorized repr Legal guardian	esentative  – name of court	Date appointed	
Name	Telep	hone number ()	
\ Address			
			/
Someone in my household i	s applying for the followin	ng programs (check one or more box	es):
☐ <b>Food Stamps</b> – Help to		re eligible, you get benefits from the date ES	
	ash to help families with children be this application or the date it is appro	ecome more independent. If eligible, benefit oved, whichever is earlier.	ts begin 30
are blind or have a disability, premiums, deductibles, and co	pregnant women, and people with chinsurance.	r children under 21, people 65 or older, peoplidren. Medicaid may also help pay Medica	are
☐ VHAP or Pharmacy As	sistance – VHAP (Vermont Hea	alth Access Plan) helps pay medical expense	es for
people 18 and older who do not <b>VPharm</b> help pay prescription <b>Vermonters</b> helps people of	ot have insurance for both doctors a ion costs for people who are blind, he of any age. Your worker will enroll	nd hospitals. VHAP-Pharmacy, VScinave a disability, or are 65 or older. Health you in the best program that you qualify for f you want help only with prescription co	ript, and hy
	ople who are blind, have a disability provides care for them so they can li	y, or are 65 or older, to help meet expenses f ve at home.	òr
	nderstand the Rights and Regiven a copy of these stateme	sponsibilities on the back of this nts and I agree to them.	
Signature of applicant or authorized representative _		Date	
Signature of person helping fill out this form		Date	
		Duic	<del></del>

#### **Rights and Responsibilities**

#### You may request a copy of this page in larger print

**True and complete information.** I understand the information I provide to ESD to apply for assistance will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility for assistance. I understand that if any information is not true, ESD may deny assistance to me.

**Reporting changes.** I understand when I get assistance, I must report changes in my situation. The changes I must report may be different depending on the benefits I get. If I am not sure which changes I must report, I will ask my worker. I understand changes may affect the amount of benefits I get. I also understand I must report changes within 10 days from when they happen.

**Social security number.** I understand that, when I apply for assistance from ESD, I must give the social security number of everyone in my household who wants assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, ESD may disregard this requirement. (42 U.S.C. §1320b-7)

ESD uses the social security number: 1) for computer processing of program benefits, support enforcement, fraud investigation, audits, and Lifeline identification; 2) to verify social security and supplemental security income; 3) to prevent individuals from receiving duplicate benefits; 4) to identify groups of cases that must have benefits changed; 5) to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service, or private claims collection agencies to verify income, determine eligibility and benefit amounts, and collect claims; 6) to determine the accuracy and reliability of information given to ESD; and 7) to make medical assistance payments.

**No Discrimination.** Federal and state law, U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, prohibit ESD from discriminating based on race, color, national origin, sex, age, disability, religion or political beliefs.

To file a discrimination complaint, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619- 3257 (TTY). USDA and HHS are equal opportunity providers and employers. Under Vermont law and rules, ESD may not discriminate based on marital status, sexual orientation or place of birth. To file a discrimination complaint, write: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 S. Main St., Waterbury, VT, 05671-1201.

**Decision on application.** ESD must make a decision on my application within 30 days (90 days if my Medicaid application is based on disability) unless delay is caused by examining physicians, an administrative emergency, or me. If I do not get a decision within 30 (or 90) days, I may call the ESD office for more information or request a fair hearing.

**Fair hearing**. I may ask for a fair hearing when my claim for assistance, benefits, or services is denied in whole or in part, or not responded to with reasonable promptness by contacting an ESD office or writing to the ESD Deputy Commissioner. (3 V.S.A. §3091)

**Quality control review.** ESD may select my application for a quality control review. If so, I agree to give proof of required information. If I am not able to give the proof needed, I authorize ESD to get it.

**Release of tax records.** I give permission to the Vermont Commissioner of taxes to disclose information from my state income tax returns to the Deputy Commissioner of ESD. (33 V.S.A. §112 (c))

**Release of medical records.** I agree that my health care providers may release my medical records when necessary for the purpose of administering ESD health care or Reach Up programs.

Assignment of medical support. As a condition of eligibility for health care assistance, I agree to assign to the state all rights to medical support and to third party payments (such as insurance) for medical care. I agree to enroll in a group health plan if the state requires me to, and I understand the state may pay the premiums. I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children, if necessary. I

understand that if I do not cooperate, my health care benefits will end although my children's health care benefits will continue.

Recovery of Medicaid payments. ESD must file a claim against my estate when I die to recover Medicaid payments made for me for services I received at age 55 or older while in a nursing facility or a home-based waiver program, and for related hospital and prescription drug services. ESD will not seek adjustment or recovery against my estate if, at the time of death, my spouse is still alive, I have surviving children who are blind, disabled, or under age 21, or ESD determines that adjustment or recovery would cause undue hardship. I understand I may find out more about recovery from my worker. (42 U.S.C. §1396p)

**Medicare Part B payments.** If I get Medicare Part B benefits while getting Medicaid, I want ESD to make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

Assignment of support rights. As a condition of eligibility for public assistance, I agree to assign all my rights to support to ESD. I understand this includes all current support owed to me while I get public assistance, all arrears owed to me that are collected during this assignment, and all arrears collected through federal tax offset during or after this assignment, up to the amount I get or have ever gotten. The noncustodial parent(NCP) will owe me amounts over the total amount of public assistance. Arrears include, but are not limited to, unpaid support obligations, debts, and court-ordered and administrative judgments. While I am on assistance, I understand the NCP will pay all support directly to the Office of Child Support (OCS). While I am waiting for ESD to grant me assistance, I will tell ESD of any support the NCP pays directly to me. After I have been granted assistance, I will immediately turn over to OCS any support the NCP pays me directly.

Consent to bill Medicaid if child receives Special Education Services. I give permission to my child's school district to bill Medicaid for the specified services listed in his/her Individual Education Plan (IEP). I understand that if I refuse consent, my refusal only affects Medicaid billing of IEP services; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to bill Medicaid for IEP services at any time; if I revoke this consent it will apply to billing for services from that date forward.

Take part in Reach Up activities. I understand that I and members of my household may have to participate in certain Reach Up activities and that my worker will tell us what we have to do and what the penalty is if we do not.

**Not fleeing prosecution.** I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand ESD must disclose information to law enforcement agencies to apprehend fleeing felons.

**No benefits from another state.** If any member of my household gets duplicate Food Stamp benefits, Medicaid, or cash assistance from another state or has been convicted in the past ten years of fraudulently misrepresenting residence to get benefits from two or more states, I must tell ESD immediately.

**Fraud penalties.** I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get Reach Up, Food Stamp, or health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to \$1,000, or an amount equal to the benefits wrongfully received. Federal and other state penalties may also apply. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Food Stamp fraud penalties. I or any household member cannot trade or sell Food Stamp benefits, use them to buy ineligible items such as alcohol or tobacco, or use someone else's food stamps. If convicted, the member may be barred from the Food Stamp program for one year for the first offense, two years for the second offense, or permanently for the third offense, and be fined up to \$250,000, imprisoned up to 20 years, or both. If convicted of buying or selling illegal drugs in exchange for food stamps, a member may be barred for two years or barred permanently for a second offense. If convicted of purchasing firearms, explosives, or ammunition with food stamps or of trafficking in Food Stamp benefits of \$500 or more, a member may be barred permanently. If convicted of falsely representing identity or residence, a member may be barred for 10 years and may be prosecuted under other federal and state laws. (7 C.F.R. \$273.16(b).)

# **Emergency Needs**

If you have little or no money for food, you may be able to get food stamp benefits within 7 days. Answer the questions in the box below to see if you can get expedited service.

₫	<b>Expedited Food Stamps for New Applicants</b>		
	Have you received food stamps this month in any state?	☐ Yes ☐ No	
	Is anyone in your household a migrant or seasonal farm worker?	☐ Yes ☐ No	
	What is your household's total income for this calendar month?		\$
	How much money does your household have in cash, checking, and savings accounts? Give your best guess if you're not sure.		\$
	What is your monthly rent or mortgage?	\$	
	How much are your monthly utilities?	\$	
gen	eral assistance application if you need emergency help.  Head of Household for Food Star	mp Benefits	
-	our household has adult parents with children or adults with parenta head of household for food stamp benefits.	al control of child	ren, you may choose
•	ESD sends notices, forms, and benefits to the head of household.		
•	If you leave this line blank, ESD will make the selection.		
	You may change the head of household when your case is reviewed in your household change.	d or when the peo	ple
Неа	nd of household	_	
	Have you visited the Food Stamp website at www.vermont  ESD use only  Interview date	foodhelp.com?	☐ Yes ☐ No  Worker
	Application Reach Up Food Stamps  Review Health care Essential person		

1. List anyone living in your home including people not asking for assistance. People in your household who are not applying do not have to give their social security number or citizenship information but must provide all other information. If you are applying for food stamps only, answer just the questions with the apple ( ) MEMB Citizenship First name Initial Last name Social security number Assistance applying for: Sex status ☐ Female ☐ Medicaid/Dr. Dynasaur ☐ Reach Up ☐ U.S. citizen ☐ Male ☐ VHAP or pharmacy ☐ Food Stamps 1. ☐ Refugee ☐ Essential Person ■ None ☐ Asylee Relationship to you Marital status Birth date Last grade completed ☐ Legal alien ☐ Civil union ☐ Divorced/dissolved ☐ Single ☐ Other Self ☐ Married ☐ Separated ☐ Widowed First name Initial Sex Social security number Citizenship Last name Assistance applying for: status ☐ Female ☐ Reach Up ☐ Medicaid/Dr. Dynasaur U.S. citizen ☐ Male ☐ Food Stamps ☐ VHAP or pharmacy 2. ☐ Refugee ☐ Essential Person □ None ☐ Asylee Birth date Relationship to you Marital status Last grade completed ☐ Legal alien ☐ Civil union ☐ Divorced/dissolved ☐ Single ☐ Other ☐ Married ☐ Separated ☐ Widowed First name Initial Social security number Citizenship Last name Sex Assistance applying for: status ☐ Medicaid/Dr. Dynasaur ☐ Female ☐ Reach Up ☐ U.S. citizen ☐ Food Stamps ☐ VHAP or pharmacy ☐ Male 3. ☐ Refugee ☐ None ☐ Essential Person ☐ Asylee ☐ Legal alien Relationship to you Marital status Birth date Last grade completed ☐ Civil union ☐ Divorced/dissolved ☐ Single ☐ Other ☐ Widowed ☐ Married ☐ Separated Citizenship First name Initial Sex Last name Social security number Assistance applying for: status ☐ Reach Up ☐ Medicaid/Dr. Dynasaur ☐ Female ☐ U.S. citizen ☐ Male ☐ Food Stamps ☐ VHAP or pharmacy 4. □ Refugee ☐ Essential Person □ None ☐ Asylee Relationship to you Marital status Birth date Last grade completed ☐ Legal alien ☐ Civil union ☐ Divorced/dissolved ☐ Single ☐ Other ☐ Married ☐ Separated ☐ Widowed First name Initial Social security number Citizenship Last name Sex Assistance applying for: status ☐ Female ☐ Reach Up ☐ Medicaid/Dr. Dvnasaur ☐ U.S. citizen ☐ Male ☐ Food Stamps ☐ VHAP or pharmacy 5. ☐ Refugee ☐ Essential Person ☐ None ☐ Asylee Relationship to you Birth date Marital status Last grade completed □ Legal alien ☐ Civil union ☐ Divorced/dissolved ☐ Single ☐ Other ☐ Married ☐ Separated ☐ Widowed First name Social security number Citizenship Initial Last name Sex Assistance applying for: status ☐ Female ☐ Reach Up ☐ Medicaid/Dr. Dvnasaur □ U.S. citizen ☐ Male ☐ Food Stamps ☐ VHAP or pharmacv 6. ☐ Refugee □ Essential Person ☐ None ☐ Asylee Relationship to you Marital status Birth date Last grade completed ☐ Legal alien ☐ Single ☐ Civil union ☐ Divorced/dissolved ☐ Other ☐ Widowed First name Initial Last name Sex Social security number Citizenship Assistance applying for: status ☐ Medicaid/Dr. Dynasaur ☐ Female ☐ Reach Up ☐ U.S. citizen ☐ Food Stamps ☐ VHAP or pharmacy ☐ Male 7. ☐ Refugee ☐ Essential Person ☐ None ☐ Asylee Relationship to you Marital status Birth date Last grade completed ☐ Legal alien ☐ Single ☐ Civil union ☐ Divorced/dissolved ☐ Other

☐ Married ☐ Separated ☐ Widowed

# Please answer the following questions about all the people listed on the previous page. If you need more room, attach another sheet of paper.

		ine past 12 months?				_
First name	Initial	Date arriv	ed in Vermont	Stat	te or country moved f	from
		L		<u> </u>		
1b. Has anyone	e received food stamp or	r cash assistance from anoth	er state since			
1996?	,				'es □ No	
irst name	Initial	State or country	Date sta		Date ended	
iist iidiile	ilitiai	State of country	Date sta	irteu	Date ended	
4 51			41			
		ed income tax credit (EITC) i	n the			
past 12 mo	nths?			□ Y	'es 🗌 No	
irst name	Initial		Date	e received		
O la annona lin		:	al an aalla na 2	□ <b>V</b>	a	
		in a facility that is not a scho	ol or college?		es □ No	
Some example	s are:	-	ol or college?	☐ <b>Y</b> €	es □ No	
Some example hospital	s are: correctional facility	residential care home	ol or college?	☐ Ye		
Some example hospital nursing h	s are: correctional facility ome treatment facility	residential care home group home				
Some example hospital	s are: correctional facility	residential care home		☐ Ye		
Some example hospital nursing h	s are: correctional facility ome treatment facility	residential care home group home		☐ Y€		INS
Some example hospital nursing h	s are: correctional facility ome treatment facility	residential care home group home		☐ Y€		
Some example hospital nursing h	s are: correctional facility ome treatment facility	residential care home group home		☐ Y€		
Some example hospital nursing h	s are: correctional facility ome treatment facility	residential care home group home		□ Y€		
Some example hospital nursing h	s are:  correctional facility ome treatment facility Initial	residential care home group home Name of	facility	□ Y€		
Some example hospital nursing h	s are:  correctional facility ome treatment facility Initial	residential care home group home Name of	facility			on
Some example hospital nursing h	s are:  correctional facility ome treatment facility Initial	residential care home group home	facility		Date of admission	on
Some example hospital nursing h	s are:  correctional facility ome treatment facility Initial	residential care home group home Name of	facility  g program?	Is health	Date of admission	on
Some example hospital nursing h	s are:  correctional facility ome treatment facility Initial	residential care home group home Name of	facility		Date of admission	S
Some example hospital nursing hospital nursing hospital state of the s	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?	Date of admission	S
Some example hospital nursing hospital nursing hospital state of the s	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?	Date of admission  Yes No Status full-time	S
Some example hospital nursing hospital nursing hospital state of the s	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?	Date of admission  Yes No Status full-time half-time	S
Some example hospital nursing h  First name  3. Is anyone in	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?	Pate of admission  Pate of admission  Pate of admission  Status  I full-time half-time less than	So
Some example hospital nursing h  First name  3. Is anyone in	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?	Pate of admission  Pate of admission  Status  full-time half-time less than full-time	S
Some example hospital nursing hospital n	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?  Yes No	Pate of admission  Pate of admission  Status  full-time half-time less than full-time half-time half-time	S half-
Some example hospital nursing h  First name  3. Is anyone in	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?  Yes No	Pate of admission  Tes No  Status  full-time half-time half-time half-time half-time half-time	Se S
Some example hospital nursing h  First name  3. Is anyone in	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?  Yes No  Yes No	Pate of admission  Pate of admission  Status  full-time half-time less than half-time half-time full-time half-time full-time	Se S
Some example hospital nursing h  First name  3. Is anyone in	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?  Yes No  Yes No  Yes No	Pate of admission  Pate of admission  Status  full-time half-time less than	So half-
Some example hospital nursing hospital nursing hospital state of the s	correctional facility ome treatment facility Initial  n high school, college, v	residential care home group home  Name of	facility  g program?  Expected	Is health insurance offered here?  Yes No  Yes No	Pate of admission  Pate of admission  Status  full-time half-time less than half-time half-time full-time half-time full-time	S half-

4. Is a	nyone known by any other nar	me, such as a maiden	name or alias?		☐ Yes	☐ No	ALIA
First nam	Current name ne Initial	Last name	First name	Other na	ame Initial	La	ast
<b>●</b> 5. Do	es anyone have a physical, me	ental. or emotional co	ndition that limits				
	tivities such as working, going	to school, or taking	care of the childre		☐ Yes	☐ No	DISA
First name	e Initial	Caused by an acc	ident? Applied for	or SSI/AABD?		Condition	
		☐ Yes ☐	No 🗌 Ye	s 🗌 No			
		☐ Yes ☐	] No 📗 Ye	s 🗌 No			
Do r	there anyone living with you wonthist your husband, wife, or civil union	n partner.			☐ Yes	□No	PARE
First nam	e Initial	Name o	child		Name of o	hild	
€ 7. Did First nam	anyone leave a job in the last	60 days or go on stri			☐ Yes	□ No	QUIT
■ Q Dec	oo anyono liyo with you who d	oog not chere your fo	nd2		☐ Yes	□ No	EATO
8. Doe First nam	es anyone live with you who do		D <b>Q /</b> nitial Last	First name		itial	EATS Last
i ii st ii aiii	o minu Luot	i not name	Luot	i not name	, , , , , , , , , , , , , , , , , , , ,	ividi	Luot

Answer question 9 only if you are applying for the Essential Person program.

<ol> <li>Does anyone live with you to provid Do not list your husband, wife, or civil union pa</li> </ol>	•		☐ Yes ☐ No ESSP
First name Initial Last name	Kind of care	Is	this paid for by another agency?
			☐ Yes ☐ No
10. Is anyone pregnant?  First name Initial	Expected due date		☐ Yes ☐ No ☐ PREG  Does this prevent her from working?  ☐ Yes ☐ No
11. Are there children in your home wh	<u> </u>	☐ Yes ☐ No ABSP	
Absent parent's full name and address  1.	Social security number (optional)	Date of birth	Children of absent parent
Your relationship to absent parent	Absent parent's current marital s	status	2
Married Divorce	Married Divorce		3
☐ Never married ☐ Dissolved civil union ☐ Civil Union	Never married Dissolv Civil Union Widow	ved civil union	4
Widowed - date	Civil Officia	eu	4
Absent parent's full name and address	Social security number (optional)	Date of birth	
2.			Children of absent parent
Your relationship to absent parent	Absent parent's current marital s	status	2
Married Divorce	Married Divorce		3
☐ Never married ☐ Dissolved civil union ☐ Civil Union	Never married Dissolv Civil Union Widow	ved civil union	4
Widowed - date	Civil Officia	eu	7
Absent parent's full name and address	Social security number (optional)	Date of birth	
3.	Commission (Cpanning)		Children of absent parent
Your relationship to absent parent	Absent parent's current marital s		2
Married Divorce  Never married Dissolved civil union		e ved civil union	3
Civil Union	Civil Union Widow		4
Widowed - date		-	7
12. If there are two parents in your hom work requirement?	e who are able to work, please li	st the parent w	vho is most likely to meet a

€ 13. Is anvoi	ne who is apply	ing covered by Medicare	e?		☐ Yes	□ No MEDI			
	nitial	<u> </u>	-	Medicare clai	m number				
Part A Start date		Part B: Start date	Start date	Part C:	Pa Start date	art D:			
Premium \$		Premium \$			Premium \$				
First name In	nitial			Medicare clai	m number				
Part A		Part B:	Start data	Part C:		art D:			
Start datePremium \$	<del></del>	Start date Premium \$	Premium \$		Start date Premium \$				
-		<u> </u>	-		· <del></del>				
		dicare prescription drug found in the bottom right-hand			☐ Yes	□ No			
First name In	nitial	Plan name	•	Contract ID	Plan ID	Plan start date			
				CMS					
				CIVIS		[			
13b. Has anyone applied for the low income subsidy for Part D (prescription coverage) through Social Security?									
First name In	nitial	Start date	O com in	Denial reason		pply because			
			Over income Over resources Other:		Over income Over resources Other:				
			Over in		Over incom				
			Over re		Over resources				
			Other:		U Other:				
veteran's or in parent not in you	military benefits	th or dental insurance place? Include insurance for any chude Medicare or state health call insurance cards.	nild in your hom		☐ Yes	□ <b>No</b>			
Name of policy		Type of coverage (check	all that apply)	Names of people covered		s, and phone number			
1.					of insura	ance company			
Policy number	Group numbe	Hospitals	Prescriptions Major Medical Outpatient						
Premium amount	Date coverage be								
\$ per									
Name of policy 2.	holder	Type of coverage (check	all that apply)	Names of people covered		s, and phone number ance company			
Policy number	Group numbe	Hospitals Dental							
Premium amount	Date coverage be	gan Other							
\$ per				<u> </u>					
14a. Could anvo	one else in vour	family be covered unde	r the above	plan?	☐ Yes	□ No			
First name		Initial		First name	Initia				
İ			1						

14b. Has health insurance ended for anyone in the past 12 months?					nonths?	□ <b>'</b>	Yes	□ No	
	Do not include state h	· · · · · · · · · · · · · · · · · · ·							LOSS
	First name	Initial	Da	ate ended			Reason		
14c.	Does anyone hav	e unpaid medical	or dental bill	s for se	rvices received in	the past 3			
		ledicaid may be able to					Yes	☐ No	
	First name	Initial	Estimate of amo	unt owed	First name	Initial		Estimate of am	ount owed
			<u> </u>						
14c.		ve unpaid medical			onths?		Yes	☐ No	
	If yes, they may help First name	you qualify for Medicaid	d or Dr. Dynasau Estimate of amo		First name	Initial		Estimate of am	ount owed
<b>4</b>					4.1				
<b>1</b> 5	•	ave cash that is no y others? Include ca			s at nome, on	П	Yes	□ No	CAGII
	First name	Initial	Amou		First name	Initial		Amount	CASH
			\$				\$		
					1				
<i>-</i>	0 D		1 114						
• 1		nave money in a b s that are owned or co-c			other institution?		Yes	□ No	BANK
	Туре	Name of owner an		Name o	of bank, credit union, or	Identifying nun	nber	Balance	•
Sovin	gs account				other institution	,			
								\$	
	gs account							\$	
	king account							\$	
Check	king account							\$	
Christ	mas club							\$	
IRA , I	Keogh Plan, 401K							\$	
Saving	gs bond or trusts							\$	
Certifi	cate of deposit (CD)							\$	
Pensi	on or retirement							\$	
Other			<u> </u>					¢	

Does any portion of these savings come from money earned as a "Working Person with Disabilities?" ☐ Yes ☐ No

17. Does anyone	e own any vehicles	s?			☐ Yes [	□ No CARS
Type of vehicle	Name of owner and		Year, make, and model	Leased?	Amount owed	For ESD use only Value
Car, truck, or van				Yes No	\$	\$
Car, truck, or van				Yes No	\$	\$
Car, truck, or van				Yes No	\$	\$
Motorcycle or ATV					\$	\$
Snow machine or jet ski					\$	\$
Trailer or boat					\$	\$
Camper or RV					\$	\$
Other					\$	\$
Name of owner and co	o-owner, if any	Т	pe of property	Location	Assessed value	Amount owed
real estate?  Do not list the ho	=	Tv	rpe of property	Location	Assessed value	PROP Amount owed
					\$	\$
					\$	\$
19. Does anyone Type of Resource			nclude resources owned by one of owner, if a			No STOK
Life insurance:  term	whole	INGI	ne or owner and co-owner, ir a	arry	Face value \$	value
					Cash value \$ Face value \$	
Life insurance:	☐ whole				Cash value \$	
Life insurance:	□ whole				Face value \$ Cash value \$	
Account set up for burial exist strict irrevocable? Yes					\$	
Burial plot						
Stocks, bonds, or mutual fu	unds				\$	
Trust funds or collections					\$	
Promissory notes					\$	

\$

Other

en. Include in such as taxe e in the next 3  Date paid	s, insurance,	Income by deductions \$	pefore cor s s s s s s s s s s s s s s s s s s s	JINC  Tips and mmissions  Tips and nmissions
s such as taxe: e in the next 3	s, insurance, 30 days,  Hours worked  Hours	Income to deduct \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	pefore cor s s s s s s s s s s s s s s s s s s s	Fips and nmissions
s such as taxe: e in the next 3	s, insurance, 30 days,  Hours worked  Hours	Income to deduct	pefore cor s s s s s s s s s s s s s s s s s s s	Fips and nmissions
	Worked	deducti	ions cor \$ \$ \$ \$ \$ \$	nmissions
Date paid		\$ \$ \$ \$ Income to deduct	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	
Date paid		\$ \$ \$ Income to deduct	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	
Date paid		\$ \$ \$ \$ Income to deduct	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	
Date paid		\$ Income be deduct	\$ \$	
Date paid		Income k	\$ pefore 1	
Date paid		Income k	before 1	
Date paid		deduct		
		I (P		
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
instead em received		☐ Yes	Value per	INKD
e from the pas at you are not		☐ Yes	s 🗆 No	DCIN
re deductions		reakfast Lu	unch Dinner	DCIN Snacks
		ro	Check all that apportunity of the come of	ау
е —		e payments from children.  Names of people paying	Names of people paying	

sa	ales, logging,	ave income from sor property rental and schedules. If you l	? Send c	opies of your most re	cent fe	deral tax return,		Yes	□ No	
		January 1 <sup>st</sup> to now.	iave not n	ieu laxes, seriu a sta	lemen	t of business income				BUSI
First nam		Initial			Type of	business	Date business b			
•										
<b>2</b> 6.	Does anyone	have income from	า work s	tudy, a student ç	rant,	or loan?	<u> </u>	Yes	☐ No	STIN
First nam	ne	Initial		Grant or loan amou	nt	Tuition and fees amount	month/		riod covered to m	nonth/year
				\$	\$					
	Social Security SSI/AABD child support	have unearned in unemployment comp worker's compensati pensions or retireme	ensation on nt	veteran's compension veteran's pension money from others	3	dividends or interest trusts or annuities insurance settlement		Yes	□ No	
		ctions, such as Medicar			child sı				Due to d	UNEA
First nam	ne	Initial	\$	ome before deductions		Type of incom	ie		Due to di	Isability?
				per					+=-	
			\$	per					☐ Yes	
			\$	per					☐ Yes	☐ No
28. First nam		pay child support	or alim	ony? Alimony paid		Child support paid		Yes	□ No	DCEX
riisi iiaii	ile .	ınıuaı		Allinony paid		Ciliiu support paiu			ipport is paid	mom
			\$	per	\$	per				
			\$	per	\$	per				
<b>∮ 28a.</b> First nam		pay for day care?	\$ List eac	per h child or adult separ Amount	\$ ately.		ny care	Yes work	□ No Reason	
			\$	per			] ] ]	looki going	ing for work g to school	

<b>9</b> 29.			er or with a disa Some examples are	bility pay for medical	expenses not	☐ Yes	□ No	
	pain relievers eyeglasses	antacids dental care	insurance premium copayments	hearing aid batteries lifeline bracelet/necklac	vitamins e			FMED
First na		Initial		Product or service	needed	How often	Average m	
						9	<b>B</b>	
							-	
						3	5	
							\$	
<b>2</b> 9a.	=	ne 60 or old doctor's office		ability pay for trips to	medical servic	es? □ Yes	□ No	
First na	me	Initial		Type and location of	fprovider	How often do you	u make these	e trips?
If you	rent only a	room, an	swer "No" to	questions 30-32a				
<b>ず</b> 30.	Does anyon	e (includin	g yourself) pay r	ent for the home you	live in?	☐ Yes	☐ No	RENT
First na		Initial	,,,	Amount you pay	What's included?	Type of hous		
				\$ per	heat utilities	Public housing? Subsidized housing?	Yes Yes	☐ No ☐ No
€ 31.	loan, condo	fees, or of		, property taxes, lot ree home you live in?  Type of payment  Mortgage	\$ per	☐ Yes	□ No	HOME Date due
					\$ per			

\$

per

■ 32. Does anyone pay for fuel or utilities?					Yes	□ No	UTIL
First name Initial			Check all tha	t apply			
	☐ heat	air condit	tioning 🔲 h	not wate	r 🔲	cooking	☐ lights
32a. Do you share any housing expenses?					Yes	□ No	
Names of people who share expenses with you	<del>                                     </del>		Shared expe	enses			
33. Does anyone pay phone or homeowners insure the street of the street	rance expe		Check all tha		Yes	□ No	PHON
	☐ buoue	nomeown	iei s ilisulatice	Ψ		per	
34. Does anyone pay for room or meals?  First name Initial	Amount a	nd how often		Chec	Yes	□ No	RBEX
	\$	per	room	□ 1-2	meals	□3 or ı	more meals
To get the most food stamp benefits, report all expenses are only applied after they are reported deductions for future benefits.  The applicant is responsible for the accuracy of information about the applicant's husband, wife	d. Expense informatio	es can be re	ported any this applic	time	to get	t these	or tnese
I give my word, under penalty of perjury true and complete to the best of my know		_	ive in this a	pplica	ation	is	
Signature of applicant or authorized representative			Date				
Signature of person helping							
fill out this form			Date				

# **Other Information and Referrals**

# **Racial and Ethnic Heritage**

	have to give this information. It is n	e following regarding the racial and ethnic her ot required to determine eligibility for any pro be sure everyone gets benefits on a fair bas	gram or the amount o			
	Ethnicity (check one)	☐ Hispanic or Latino	☐ Not Hispanic or	Latino		
	Race (check all that apply)	<ul><li>☐ American Indian or Alaska Native</li><li>☐ Black or African American</li><li>☐ White</li></ul>	☐ Asian ☐ Native Hawaiian Islander	or other Pa	cific	
	Children who are members of feder Dynasaur premium. Call 1-800-250	ally designated American Indian or Alaska N 0-8427 for more information.	ative tribes may not ha	ave to pay a	Dr.	
Voter F	Registration					
	•	ere you live now, would you like a voter regis will be considered to have decided not to reg	• •	☐ Yes	□ No	
	Applying to register or declining to register to vote will not affect your eligibility for benefits or the amount of assistance that ESD will provide you.					
	If you want help filling out the voter registration application, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.					
	If you believe that someone has interfered with your right to register or decline to register to vote, you may file a complaint with the Secretary of State's Office at Redstone Building, 26 Terrace Street, Drawer 09, Montpelier, VT 05609-1101 (telephone 1-802-828-2363).					
Referra	als to other programs					
	<b>Lifeline</b> is a monthly credit on your home or Unicel wireless phone bill. <b>Link Up</b> is payment for part of the installation cost of a new phone. You can get these credits if you are an adult recipient of ESD benefits. The phone must be listed in your name or you must pay part of the bill. <i>Call your telephone company for more information</i> .					
		ifeline credit now, would you like to?		☐ Yes	□ No	
	Fuel Assistance – Help paying heating bills. Applications are accepted July 15 through the last day of February. Your local office can give you an application during this time; otherwise you can ask the Office of Home Heating Fuel Assistance (OHHFA) to may you an application in June. Call OHHFA at 1-800-479-6151 for more information or an application.					
	Would you like a brochure		.,	☐ Yes	□ No	
	Weatherization – Help with insulating toll free 1-877- 919-2299 for more in	r apartment to lower y	our heating o	costs. Call		
	Would you like a brochure about w	veatherization services?		☐ Yes	☐ No	
	The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Health screening, nutrition education, and food for pregnant women, nursing women, and children under five. Call your local Department of Health office for more information about WIC.					
		iving WIC, would you like to? t make an appointment with your local Health	Department office.	☐ Yes	□ No	
		A) - Learn about finances and save money for money in an IDA is matched by state money cation Agency for more information.				
	Would you like a brochure	about IDAs?		☐ Yes	□ No	



## Take this page with you

## It has information that may be helpful, and it is your copy of your Rights and Responsibilities.

### You must report changes



#### Reporting requirements for food stamps

If the only benefit I get is food stamps, I must report:

- my household expenses when I am determined eligible for food stamps and when my case is reviewed. If I don't, I lose the right to a deduction of these expenses during this period.
- when my household income in a calendar month reaches 130% of the federal poverty level for my household size. Your worker can tell you this amount. I must report this no later than 10 days after the end of the month it happens.
- when the status of an able-bodied adult without dependents (ABAWD) in my household changes. Some examples are:
  - loses a job
  - reduces hours of work
  - becomes exempt

#### Reporting requirements for other programs

If I get health care, Reach Up, or PSE benefits, I must report when someone in my household:

- has an increase or decrease in the number of regularly scheduled hours of work;
- gets a job or stops working;
- has a change in the amount of money coming into the household, including winnings;
- moves in, moves out, gets married, becomes pregnant, or has a baby;
- is given money, land, a car, or other property; or
- gets or changes private health insurance. including prescription coverage.

See the Agreement to Report Change, ESD 201A, for exactly what you must report. You may report changes to your local office in person, by telephone, by writing, or by sending a Change Report, ESD 200. If you have any questions about what changes you must report, ask your worker.

# **Contact information**

1-800-287-0589 www.dcf.state.vt.us

#### People who are deaf or hard of hearing can call the statewide relay service at 711

If you do not speak English, we can provide free translation for our services. Please tell us if you need an interpreter for any language.

#### Barre

5 Perry Street, Suite 150 Barre, VT 05641-4270 Tel: (802) 479-1041 Tel: 1-800-499-0113

150 Veterans Memorial

#### Bennington

Drive, Suite 6 Bennington, VT 05201-1918 Tel: (802) 442-8541

Tel: 1-800-775-0527

#### **Brattleboro**

232 Main Street P.O. Box 70 Brattleboro, VT 05302-0070 Tel: (802) 257-2820

Tel: 1-800-775-0515

#### Burlington

101 Cherry Street, Suite 101 Burlington, VT 05401-4405 Tel: (802) 863-7365 Tel: 1-800-775-0506

#### Middlebury

700 Exchange Street. Suite 103 Middlebury, VT 05753-9943 Tel: (802) 388-3146 Tel: 1-800-244-2035

#### Morrisville

63 Professional Drive, Suite 4 Morrisville, VT 05661-8522 Tel: (802) 888-4291 Tel: 1-800-775-0525

#### **Newport**

100 Main Street, Suite 240 Newport, VT 05855-4898 Tel: (802) 334-6504 Tel: 1-800-775-0526

#### Rutland

320 Asa Bloomer Building State Office Building Rutland, VT 05701-9400 Tel: (802) 786-5800 Tel: 1-800-775-0516

#### **Springfield**

100 Mineral Street, Suite 201 Springfield, VT 05156-9900 Tel: (802) 885-8856

Tel: 1-800-589-5775

#### St. Albans

20 Houghton Street Suite 313 St. Albans, VT 05478-9922 Tel: (802) 524-7900 Tel: 1-800-660-4513

#### St. Johnsbury

67 Eastern Avenue, Suite 7 St. Johnsbury VT 05819-9950 Tel: (802) 748-5193 Tel: 1-800-775-0514

#### White River Junction

224 Holiday Dr., Suite A White River Jct., VT 05001-2097 Tel: (802) 295-8855

Tel: (802)1-800-775-0507

## **Rights and Responsibilities**

#### You may request a copy of this page in larger print

**True and complete information.** I understand the information I provide to ESD to apply for assistance will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility for assistance. I understand that if any information is not true, ESD may deny assistance to me.

**Reporting changes.** I understand when I get assistance, I must report changes in my situation. The changes I must report may be different depending on the benefits I get. If I am not sure which changes I must report, I will ask my worker. I understand changes may affect the amount of benefits I get. I also understand I must report changes within 10 days from when they happen.

**Social security number.** I understand that, when I apply for assistance from ESD, I must give the social security number of everyone in my household who wants assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, ESD may disregard this requirement. (42 U.S.C. §1320b-7)

ESD uses the social security number: 1) for computer processing of program benefits, support enforcement, fraud investigation, audits, and Lifeline identification; 2) to verify social security and supplemental security income; 3) to prevent individuals from receiving duplicate benefits; 4) to identify groups of cases that must have benefits changed; 5) to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service, or private claims collection agencies to verify income, determine eligibility and benefit amounts, and collect claims; 6) to determine the accuracy and reliability of information given to ESD; and 7) to make medical assistance payments.

**No Discrimination.** Federal and state law, U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, prohibit ESD from discriminating based on race, color, national origin, sex, age, disability, religion or political beliefs.

To file a discrimination complaint, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers. Under Vermont law and rules, ESD may not discriminate based on marital status, sexual orientation or place of birth. To file a discrimination complaint, write: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 S. Main St., Waterbury, VT, 05671-1201.

**Decision on application.** ESD must make a decision on my application within 30 days (90 days if my Medicaid application is based on disability) unless delay is caused by examining physicians, an administrative emergency, or me. If I do not get a decision within 30 (or 90) days, I may call the ESD office for more information or request a fair hearing.

**Fair hearing**. I may ask for a fair hearing when my claim for assistance, benefits, or services is denied in whole or in part, or not responded to with reasonable promptness by contacting an ESD office or writing to the ESD Deputy Commissioner. (3 V.S.A. §3091)

**Quality control review.** ESD may select my application for a quality control review. If so, I agree to give proof of required information. If I am not able to give the proof needed, I authorize ESD to get it.

Release of tax records. I give permission to the Vermont Commissioner of taxes to disclose information from my state income tax returns to the Deputy Commissioner of ESD. (33 V.S.A. §112 (c))

**Release of medical records.** I agree that my health care providers may release my medical records when necessary for the purpose of administering ESD health care or Reach Up programs.

**Assignment of medical support.** As a condition of eligibility for health care assistance, I agree to assign to the state all rights to medical support and to third party payments (such as insurance) for medical care. I agree to enroll in a group health plan if the state requires me to, and I understand the state may pay the premiums. I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children,

if necessary. I understand that if I do not cooperate, my health care benefits will end although my children's health care benefits will continue.

Recovery of Medicaid payments. ESD must file a claim against my estate when I die to recover Medicaid payments made for me for services I received at age 55 or older while in a nursing facility or a home-based waiver program, and for related hospital and prescription drug services. ESD will not seek adjustment or recovery against my estate if, at the time of death, my spouse is still alive, I have surviving children who are blind, disabled, or under age 21, or ESD determines that adjustment or recovery would cause undue hardship. I understand I may find out more about recovery from my worker. (42 U.S.C. §1396p)

**Medicare Part B payments.** If I get Medicare Part B benefits while getting Medicaid, I want ESD to make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

Assignment of support rights. As a condition of eligibility for public assistance, I agree to assign all my rights to support to ESD. I understand this includes all current support owed to me while I get public assistance, all arrears owed to me that are collected during this assignment, and all arrears collected through federal tax offset during or after this assignment, up to the amount I get or have ever gotten. The noncustodial parent(NCP) will owe me amounts over the total amount of public assistance. Arrears include, but are not limited to, unpaid support obligations, debts, and court-ordered and administrative judgments. While I am on assistance, I understand the NCP will pay all support directly to the Office of Child Support (OCS). While I am waiting for ESD to grant me assistance, I will tell ESD of any support the NCP pays directly to me. After I have been granted assistance, I will immediately turn over to OCS any support the NCP pays me directly.

Consent to bill Medicaid if child receives Special Education Services. I give permission to my child's school district to bill Medicaid for the specified services listed in his/her Individual Education Plan (IEP). I understand that if I refuse consent, my refusal only affects Medicaid billing of IEP services; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to bill Medicaid for IEP services at any time; if I revoke this consent it will apply to billing for services from that date forward.

**Take part in Reach Up activities.** I understand that I and members of my household may have to participate in certain Reach Up activities and that my worker will tell us what we have to do and what the penalty is if we do not.

**Not fleeing prosecution.** I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand ESD must disclose information to law enforcement agencies to apprehend fleeing felons.

No benefits from another state. If any member of my household gets duplicate Food Stamp benefits, Medicaid, or cash assistance from another state or has been convicted in the past ten years of fraudulently misrepresenting residence to get benefits from two or more states, I must tell ESD immediately.

**Fraud penalties.** I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get Reach Up, Food Stamp, or health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to \$1,000, or an amount equal to the benefits wrongfully received. Federal and other state penalties may also apply. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Food Stamp fraud penalties. I or any household member cannot trade or sell Food Stamp benefits, use them to buy ineligible items such as alcohol or tobacco, or use someone else's food stamps. If convicted, the member may be barred from the Food Stamp program for one year for the first offense, two years for the second offense, or permanently for the third offense, and be fined up to \$250,000, imprisoned up to 20 years, or both. If convicted of buying or selling illegal drugs in exchange for food stamps, a member may be barred for two years or barred permanently for a second offense. If convicted of purchasing firearms, explosives, or ammunition with food stamps or of trafficking in Food Stamp benefits of \$500 or more, a member may be barred permanently. If convicted of falsely representing identity or residence, a member may be barred for 10 years and may be prosecuted under other federal and state laws. (7 C.F.R. §273.16(b).)